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Page 238

Provisions of the Medicare Bill

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The Medicare prescription drug benefit that President Bush signed into law Dec. 8 (PL 108-173) was the largest expansion of benefits in the 38-year history of the federal health care program for the elderly and disabled. The law not only adds drug coverage to Medicare, but also gives extra funds to health care providers in rural areas and creates a savings account that permits all Americans to set aside money on a tax-free basis for unreimbursed medical expenses. *(2003 CQ Weekly, p. 2883)*

The measure was the culmination of years of congressional consideration of the politically explosive topic. In the 106th and the 107th Congresses, House GOP leaders had passed their Medicare prescription drug legislation through the chamber with mostly Republican votes, but each time the bills never made it through the more closely divided Senate. In the 108th Congress, Republicans were in charge of both chambers and were eager to deliver on the issue after campaigning on it for years.

Also, a growing federal deficit contributed to fears that the $400 billion in the fiscal 2004 budget resolution for a Medicare drug benefit would not be available again for many years.

The difficulties of passing such sweeping legislation in an election year also helped move lawmakers from both parties, as well as the administration, to seek compromise. But all sides still had to resolve deep philosophical differences that had stalled the legislation before, such as how the benefit should be structured and what role private insurers should play in the design and delivery of a drug benefit for more than 40 million elderly and disabled Medicare beneficiaries.

The House and Senate passed their respective Medicare drug bills in late June and conferees were appointed in July. Conference Chairman Bill Thomas, R-Calif., decided to exclude all but two Democrats from the talks — Sens. John B. Breaux of Louisiana and Max Baucus of Montana — because he concluded only those two would be willing to compromise with Republicans.

Conference negotiations continued into the fall, with conferees meeting almost daily to resolve differences between the House and Senate bills.

Senate Majority Leader Bill Frist, R-Tenn., House Speaker J. Dennis Hastert, R-Ill., and House Majority Leader Tom DeLay, R-Texas, intervened in mid-November when the talks bogged down over the issue of "premium support," a provision in the House bill that would have required Medicare's traditional fee-for-service plan to compete directly with private insurers beginning in 2010 on price and benefits.

For many House conservatives, it was a critical provision to help guarantee the solvency of the program for future generations. Many Democrats, concerned that it would undermine the role of the government in providing health care to the elderly, opposed it.

To appease conservatives and win Democratic votes, conferees scaled back the concept of competition, creating instead a demonstration project that would take place in six metropolitan statistical areas for six years. And, although Democrats disliked the health savings accounts in the bill, they were retained to help win conservative support for the legislation.

The final measure squeaked through the House, but was cleared by the Senate by a comfortable margin. The House adopted the conference report on the bill in the early morning hours of Nov. 22 on a 220-215 vote after GOP leaders left the floor vote open for two hours and 53 minutes — believed to be the longest recorded tally since electronic voting began in 1973 — while party leaders and the president, who called wavering members, worked to secure the votes needed.

In the Senate, supporters of the conference report overcame two attempts to derail it. Edward M. Kennedy, D-Mass., tried to filibuster the measure Nov. 24, but failed. Later that day, Minority Leader Tom Daschle, D-S.D., raised a point of order against the bill, saying it violated budget rules, but he was defeated when the Senate voted 61-39 to waive all budget points of order against the measure. The next day, Nov. 25, the Senate adopted the Medicare conference report by a 54-44 vote, clearing it for the president.

Following are the major provisions of PL 108-173:

Prescription Drug Benefit

• **Options for coverage.** Seniors will be able to receive a prescription drug benefit through insurance plans that offer drug-only coverage or through "Medicare Advantage" plans that will provide both drug coverage and coverage for other health services, such as hospital stays and doctors' visits. Medicare Advantage plans will be offered on a local basis and on a regional basis. Medicare Advantage plans will replace the "Medicare+Choice" program, in which managed care plans provided coverage to Medicare beneficiaries.

• **Temporary drug cards.** Beginning about May 2004, beneficiaries may enroll in a "Medicare-endorsed" prescription drug card program, which Department of Health and Human Services (HHS) officials estimate will save consumers 15 percent to 25 percent on their drug costs until the drug benefit begins on Jan. 1, 2006.

Beneficiaries will be able to choose from at least two cards offered by different drug manufacturers, retailers, insurers or some other private groups. A beneficiary enrolled in one card in 2004 can change that selection in 2005. Beneficiaries can have as many non-government drug discount cards as they wish. The cards will not exist after Dec. 31, 2005.

• **Drug card subsidy.** Beneficiaries whose incomes are less than 135 percent of the calculated poverty level ($10,874 in 2002 for a married couple over the age of 65) will receive a subsidy of $600 in 2004 and 2005 to help them pay for prescription drugs, in addition to a drug card. Beneficiaries with incomes between 100 percent and 135 percent of the poverty level will have to pay 10 percent of the cost of each prescription. Those whose incomes are less than 100 percent of the poverty level will pay 5 percent of the cost of each prescription.

A card sponsor may charge an annual enrollment fee of up to $30, and the government will pay the fee for individuals whose incomes are less than 135 percent of the poverty level.

• **Enrollment.** The drug benefit, known as Medicare Part D, begins Jan. 1, 2006. It will be optional for Medicare beneficiaries.

A six-month initial enrollment period begins Nov. 15, 2005, for beneficiaries. Those who try to enroll after that period will incur a financial penalty: Their monthly premiums will be increased by either an amount the secretary of Health and Human Services determines is actuarially sound, or 1 percent for each month the individual does not have coverage after the end of the initial enrollment period, whichever is greater.

The HHS secretary will establish enrollment periods for special circumstances, such as involuntary loss of prescription coverage under a group health plan.

The HHS secretary is also required to disseminate comparative information to beneficiaries during subsequent annual open enrollment periods.

• **Design of benefit.** Beneficiaries must meet a $250 yearly deductible before benefits begin. From that point on for the rest of the year, the government will pay 75 percent of drug costs up to $2,250.

Beyond that point, government coverage will not resume until a beneficiary has spent a total of $3,600 out of pocket. After that, the government will pick up 95 percent of remaining drug costs, known as catastrophic coverage, for the rest of the year. Money that beneficiaries spend on drugs not included on a plan's list of approved medicines will not be counted toward the $3,600.

Insurers must adhere to the $250 deductible and the $3,600 level for the commencement of catastrophic drug coverage, but otherwise can adjust cost-sharing and other elements of the benefit as long as it is actuarially equivalent to the standard Medicare drug benefit. Once beneficiaries select a plan, they must remain in the plan for a year.

Only the beneficiaries' own spending, money paid by a family member, federal subsidies or money from a state pharmaceutical assistance program can count toward the

$3,600 out-of-pocket expenses cap. Money paid by a former employer on behalf of a retiree will not count toward the $3,600 level.

Beginning in 2007, the amount of the deductible, the $2,250 limit and $3,600 cap will be indexed annually to the annual percentage increase in the average per-capita expenditure for prescription drugs for Medicare beneficiaries.

• **Premiums.** Beneficiaries will pay an estimated premium of $35 a month in 2006, which can be deducted directly from a beneficiary's Social Security check, through an electronic funds transfer or through other means as defined by the HHS secretary. Premiums can change from year to year.

• **Covered drugs.** Prescription drugs, biological products and insulin, including medical supplies associated with the injection of insulin as defined by HHS secretary, will be covered. Drugs that are excluded from Medicaid coverage, such as those that aid in weight loss or gain, can be excluded from coverage. Drugs that are paid for under Medicare Part A and B are excluded, as are drugs that do not meet Medicare's definition of medically necessary or were not prescribed by a physician.

Every participating insurance plan will have a pre-approved list, or formulary, of drugs eligible for coverage.

• **Functional equivalence.** The HHS secretary is prohibited from publishing regulations or any other guidance saying that there is a "functional equivalence" between two medicines. But the secretary is not prohibited from deeming a particular drug to be identical to another drug if the two products are pharmaceutically equivalent and bioequivalent as determined by the commissioner of the Food and Drug Administration.

• **Pharmacies and formularies.** Insurers will have to accept any pharmacies willing to agree to the plan's terms and conditions and must have enough pharmacies in their network — other than mail order or Internet — so that beneficiaries have convenient access to drugs.

If a plan uses a pre-approved list of covered drugs, it will have to have a committee to review how well the list, or formulary, works. The committee must have at least one practicing physician and one practicing pharmacist who have expertise in the care of elderly or disabled persons and are free of any conflicts of interest. The majority of members on the committee must be physicians or pharmacists. Therapeutic categories and classes of drugs can be changed once a year. But the HHS secretary may permit other changes to take into account new therapeutic uses and newly approved covered drugs.

Beneficiaries will be able to appeal to obtain coverage for a drug not on the formulary if the beneficiary's prescribing physician determines that the covered drugs will not be as effective for the individual or has adverse effects.

A plan can change its list of drugs at any time. "Appropriate notice" must be provided to enrollees, pharmacists, pharmacies and physicians before a drug is removed from a formulary or its tier status is changed.

• **Electronic prescription program.** The HHS secretary must set standards that would allow prescription information and information on a patient's medical history to be transmitted electronically. Information to be transmitted includes items such as drugs covered under a plan's formulary, information on the drug being prescribed and other drugs listed in the patient's medical history and information on the availability of lower-cost, therapeutically appropriate alternative drugs.

• **Fallback coverage.** Beneficiaries will be guaranteed access to at least one prescription drug plan and one integrated plan — such as a health maintenance organization or a preferred provider organization — from which to choose coverage. Two prescription drug plans must be available if no integrated plan is available.

If no private plans bid to offer coverage in a region, the government will provide a drug plan for beneficiaries. It cannot have just one fallback plan that covers the entire nation.

Low-Income Beneficiaries

• **Medicaid beneficiaries.** Low-income beneficiaries who qualify for both Medicare and Medicaid, known as "dual eligibles," are eligible for the Medicare drug benefit and qualify for a full premium subsidy for the lowest-cost plan. Dual eligibles with incomes up to 100 percent of the poverty level will have no deductible and no coverage gaps. But they will be required to make payments of $1 for each generic drug purchase and $3 for each brand-name prescription until they meet the $3,600 out-of-pocket threshold. They will have no co-payment requirements after they get to that threshold.

Dual eligibles with incomes above 100 percent of poverty will qualify for a full-premium subsidy for the lowest-cost plan and will have no deductible or coverage gap. But they will be required to make payments of $2 for each generic drug purchase and $5 for each brand-name prescription until they meet the $3,600 out-of-pocket threshold. They will have no co-payment requirements after they hit that threshold.

The deductible amounts are increased each year beginning in 2007 by the annual percentage increase in per capita beneficiary expenditures for Part D covered drugs. The cost-sharing amounts are increased by the increase in the consumer price index. State Medicaid programs and the Social Security Administration will determine which individuals can qualify.

• **Medicaid funds.** In 2006, states must return to the federal government 90 percent of what they would have spent on drug coverage for dual eligibles, resulting in a 10 percent savings for states from what they now spend. This return, known as a "clawback," will be

reduced annually over 10 years until it reaches 75 percent, resulting in an annual 25 percent savings for states.

• **Non-Medicaid, low-income beneficiaries.** Low-income beneficiaries who are not dual eligibles can also receive some financial help. Those beneficiaries with incomes below 135 percent of poverty and who have no more than $6,000 in assets as an individual and $9,000 as a couple will not have to meet a deductible but must make co-payments of $2 for generics and $5 for brand-name drugs. They will not have any cost-sharing once they reach the annual $3,600 threshold.

Enrollees with incomes below 150 percent of poverty who have assets of no more than $10,000 per individual and $20,000 for a couple will pay a $50 annual deductible, 15 percent cost sharing for purchases up to the annual $3,600 threshold. Above that level, they will make co-payments that are the greater of either 5 percent of the drug purchase or $2 per generic prescription and $5 per brand-name prescription. Those co-payment amounts will be indexed to grow annually according to the growth in Medicare per capita drug spending. State Medicaid programs and the Social Security Administration will determine which individuals can qualify.

Private Insurers

• **Bidding process.** Bids to provide prescription drug plans and Medicare Advantage plans must include a variety of items, such as information on the prescription drug to be provided and the size of the service area. The HHS secretary has the authority to negotiate the terms and conditions of the plans. The HHS secretary may not interfere with the negotiations between drug manufacturers and pharmacies and prescription drug sponsors, nor may the secretary require a particular formulary or institute a price structure for the reimbursement of Medicare-covered drugs.

• **Payments to insurers.** In 2006, the HHS secretary will determine Medicare Advantage payment rates by comparing health plan bids to a benchmark amount set specifically for local plans and for regional plans. For local Medicare Advantage plans, payment will be based on county payment rates for the service area. Regional plans are paid their bids. Bids are used in proportion to the private plan national market share and a statutory formula to determine a benchmark. If a plan bids below the benchmark, 75 percent of the savings will go to beneficiaries while 25 percent will be returned to the government.

For both prescription drug plans and Medicare Advantage plans, Medicare will cover 74 percent of the insurance plans' cost for basic drug coverage. For beneficiaries whose drug costs exceed $3,600, the government will provide 80 percent "reinsurance" of allowable costs.

Medicare also will help cover insurers' costs using target levels, known as "risk corridors," that are based on a variety of factors such as total amounts paid to the plan and administrative expenses assumed in the plan's bid. For example, in 2006 and 2007,

the government will cover 75 percent of insurers' costs that come in between 2.5 percent and 5 percent above the target level. Anything above 5 percent will be covered by the government at 80 percent.

If the cost for a plan falls below the target, the insurer must share those savings with beneficiaries and the government. It must return in some form 75 percent of the savings to beneficiaries and 25 percent to the government if costs fall between 2.5 percent and 5 percent below the target level. For savings of more than 5 percent below the target, the insurer must share 80 percent with beneficiaries, with 20 percent going to the government.

From 2008 to 2011, plans will receive less help from the government if their costs exceed the target level.

• **Negotiated pricing.** Insurers will negotiate discounts with manufacturers and suppliers of covered drugs. Each plan must disclose to the HHS secretary details of any price concessions. Drug discounts will not be applicable to Medicaid's "best price" provisions.

• **Incentive fund.** From Jan. 1, 2007, through Dec. 31, 2013, approximately $10 billion will be available to provide incentives for health plans to enter each region or to stay in hard-to-serve regions. The HHS secretary is allowed to use the money to respond to market conditions. but if the money is used for two consecutive years, the secretary must report to Congress on the underlying market conditions. Beginning in 2008, annual reports will be required to monitor the amount of money spent and evaluate the quality of plans that receive fund money.

• **Payments for Medicare Advantage plans.** In 2004, Medicare Advantage plans will be paid the higher of four different amounts: a minimum, or floor, rate set by the Centers for Medicare and Medicaid Service; a blend of local and national payment rates; a rate reflecting a minimum increase from the previous year's rate; or 100 percent of payments made for persons enrolled in traditional Medicare programs.

For 2005 and beyond, the minimum percentage increase will be the greater of a 2 percent increase over the previous year's payment rate or the previous year's payment increased by the percentage of the national per capita Medicare Advantage growth.

• **Size of Medicare Advantage regions.** The HHS secretary will establish 10 to 50 regions across the nation. Plans wishing to participate in this program will be required to serve an entire region, and the plans will be allowed to serve more than one region. There will be no limit on the number of plans per region.

The HHS secretary must publish a list of Medicare Advantage regions by Jan. 1, 2005. To the extent possible, each region should include at least one state, not divide states across regions and should include multi-state metropolitan statistical areas in a single region.

To the extent possible, Medicare Advantage regions will be the same as regions for prescription drug plans.

• **Beneficiary rebate.** Medicare Advantage plans must provide an enrollee with a monthly rebate equal to 75 percent of any average per capita savings. To ensure that beneficiaries' savings are uniform, the benchmark and the bid will be adjusted on a state or regional basis. The government will retain 25 percent of the average per capita savings.

Separately, the HHS secretary can waive or modify requirements that hinder the ability of employers, labor organizations or trustees of a fund to offer a Medicare Advantage plan. The Medicare Advantage plan can also restrict enrollment to individuals who are beneficiaries and participants of such a plan.

• **Competition with traditional Medicare.** Beginning in 2010, private insurance companies will compete against Medicare on price in six metropolitan statistical areas for six years. To qualify, a metropolitan statistical area must have at least 25 percent of eligible Medicare beneficiaries enrolled in a local coordinated Medicare Advantage plan and at least two coordinated Medicare Advantage local plans offered by different organizations. The HHS secretary will select the demonstration areas.

Plan bids from private plans and rates for traditional fee-for-service Medicare will be averaged to create a benchmark for competitive bidding. At the end of the demonstration, the HHS secretary will submit a report to Congress that includes an evaluation of the demonstration's financial effect on Medicare, changes in access to physicians and other health care providers and beneficiary satisfaction under the demonstration project and under Medicare's fee-for-service program. Congress then will have to decide whether to expand the demonstration project.

Other Drug Coverage Options

• **Retiree drug coverage.** Employers who provide retiree drug coverage will receive a government subsidy equal to 28 percent of those costs above $250 but not greater than $5,000 per retiree. That amount will be adjusted annually by the percentage increase in Medicare per capita prescription drug costs. Employers will not have to pay taxes on subsidy payments.

Qualified retiree plans will be able to have flexibility on plan design, formularies and networks.

Employers will be able to provide premium subsidies and cost-sharing assistance for retirees who enroll in a Medicare drug plan and integrated plans.

• **Medigap.** No new supplemental Medigap plans with drug coverage will be sold, issued or renewed after Jan. 1, 2006, for beneficiaries who enroll in the Medicare drug

benefit. Beneficiaries who enroll in the drug benefit could still buy Medigap policies that cover costs other than those for prescription drugs.

Medigap will also feature two new benefit packages that will provide partial coverage of Part A and Part B beneficiary cost sharing.

Providers

• **Hospitals.** For fiscal 2004, the rate of change in payments to hospitals is to match the rate of change in the price for a "market basket" of certain goods used by hospitals.

For fiscal 2005, 2006 and 2007, hospitals will have to furnish information on quality to the Centers for Medicare and Medicaid Services or face a reduction in payments.

Teaching hospitals will receive an additional $400 million in payments over the next decade. A redistribution of unused resident positions will increase both direct and indirect graduate medical education spending by an anticipated $800 million from fiscal 2004 through fiscal 2013.

Low volume hospitals, with fewer than 800 discharges a year that are 25 road miles away from a similar hospital may qualify for up to a 25 percent increase in Medicare payments.

Payments to outpatient hospitals for covered drugs are expected to increase by $700 million from fiscal 2004 through fiscal 2008.

For 18 months from the date of enactment, physicians will not be able to refer Medicare patients to new specialty hospitals in which they have an investment interest. Existing hospitals or those under construction as of Nov. 18, 2003, are not included. Specialty hospitals are also prohibited from increasing the number of physician investors as of Nov. 18, 2003, or to expand the number of illnesses they treat.

By March 2005, the Medicare Payment Advisory Commission, or MedPAC, will complete a study on the effects of a physician having an ownership interest in an entire hospital, as opposed to an interest in only a specialty department.

A one-time geographic reclassification process to increase hospitals' wage index values for three years is expected to increase hospital payments by $900 million from 2004 through 2008. The HHS secretary will establish a wage index appeals process by Jan. 1, 2004. Hospitals wishing to be reclassified must submit an appeal to the Medicare Geographic Classification Review Board by Feb. 15, 2004. Reclassifications will be effective for a three-year period beginning April 1, 2004.

If a Medicare Advantage plan is unable to reach an agreement on payments with a hospital that is essential to service beneficiaries in a particular region, the HHS secretary can use money from a special fund to help cover the difference in payment between what

Medicare Part A would pay the hospital and how much the hospital charges. To qualify, the hospital must demonstrate why its costs exceed the Medicare Part A payment rate. Beginning in 2006, $25 million will be available for such payments, increasing each year by the growth in the hospital market basket percentage.

• **Physicians.** The law blocks a 4.5 percent cut in Medicare payments in 2004 and an additional cut in 2005. Instead, doctors will receive at least a 1.5 percent increase in 2004 and 2005. In calendar years 2004 and 2005, Alaskan physicians will receive higher practice cost payments.

Beginning in 2004, the HHS secretary is required to make adjustments in practice expenses for physicians who administer certain drugs in their offices, including chemotherapy administrations. The HHS secretary is also required to "promptly evaluate" existing drug administration codes for physicians' services to ensure accurate reporting and billing for those services.

An additional payment will be made for drug administration services furnished from April 1, 2004, through Dec. 31, 2005. The payment for 2004 is 32 percent; for 2005, it is 3 percent.

The Medicare Payment Advisory Commission, or MedPAC, is required to review the payment changes as they affect payments for items and services furnished by other specialists. The report on oncologists' payments is due by Jan. 1, 2006, and the report on other specialists is due Jan. 1, 2007.

Dentists, podiatrists and optometrists will be able to privately contract with Medicare beneficiaries.

The formula for calculating the sustainable growth rate, which is a factor in determining how much Medicare pays physicians, will be modified. Beginning with 2003, the gross domestic product, which is used in the calculation, will be based on the annual average change over the preceding 10 years.

• **Laboratories.** Payment rates to laboratories will be frozen for five years.

• **Home health care.** For the last quarter of 2003 and the first quarter of 2004, payments to home health agencies will be increased by the rate of change in the price of a market basket of items used in that industry. For the remainder of 2004, 2005 and 2006, the payment will be the rate of change in that market basket minus 0.8 of a percentage point.

• **Durable medical equipment.** Rates for most durable medical equipment, such as walkers, crutches and bedpans, and services surrounding them will be frozen from fiscal 2004 to 2008. For 2005, payments for certain items, including oxygen and oxygen equipment, will be reduced to the price paid by the Federal Employee Health Benefits Program.

Competitive bidding in the 10 largest metropolitan statistical areas will begin in 2007, with a goal of 80 such areas in 2009. The HHS secretary could exempt items and services for which competitive bidding would not be likely to result in significant savings.

The HHS secretary must establish and implement quality standards for suppliers of durable medical equipment items, such as orthotics and prosthetic devices.

The HHS secretary must report to Congress by July 1, 2009, on savings, reductions in cost-sharing, access to items and services and beneficiary satisfaction under competitive bidding.

• **Changes in anti-kickback statute.** Remuneration in the form of a contract, lease, grant, loan or other agreement between a public or a nonprofit private health center and an individual or entity providing goods or services to the center will not be a violation of the anti-kickback statute if such an agreement would contribute to the ability of the health center to maintain or increase the availability or quality of services provided to a medically underserved population. The HHS secretary will be required to establish standards to evaluate such arrangements.

• **AIDS patients at skilled nursing facilities.** The per-diem payments to skilled nursing facilities that treat AIDS patients will rise 128 percent. The increase may change, however, after the HHS secretary reviews each center to determine the level of costs incurred to care for patients.

• **Therapy caps.** Caps on the amount of outpatient therapy individuals can receive are suspended until Dec. 31, 2005. The HHS secretary must report to Congress by March 31, 2004, on alternatives to a single annual dollar cap on outpatient therapy and differences in how therapies are used and delivered from region to region. The General Accounting Office must report to Congress by Oct. 1, 2004, on conditions or diseases that may justify waiving the application of therapy caps.

• **Ambulatory surgical centers.** Starting April 1, 2004, the payment update for these centers, which are facilities where Medicare patients go for outpatient procedures such cataract removal or colonoscopies, will be the government's consumer price index for all urban consumers, estimated as of March 31, 2003, minus 3.0 percentage points. In fiscal 2005, for the last quarter of calendar year 2005 and each of the calendar years 2006 through 2009, the update will be zero.

• **Medicaid disproportionate share.** Hospitals that serve a large number of uninsured patients and Medicaid patients, known as disproportionate share hospitals, will receive more federal money to compensate them for that care. In fiscal 2004, payments will be set at 116 percent of fiscal 2003 allotments and will not be subject to the 12 percent cap on state allotments for medical assistance payments. States will receive the same amount for subsequent fiscal years unless the HHS secretary determines that the amount that states would have received before enactment of the Medicare drug law would equal or no

longer exceed the fiscal 2004 payments. If that is the case, states' payments would rise by the same rate of increase in the consumer price index for the previous fiscal year.

As a condition of receiving such payments, each state must submit to the HHS secretary an annual report for the previous fiscal year identifying disproportionate share hospitals that received a payment and how much they received.

Rural package

• **Hospitals.** In fiscal 2004, hospitals in rural and small urban areas will receive a permanent 1.6 percent increase to Medicare's base rate, or the payment hospitals receive for each discharged patient. Higher payments will be made to rural and small urban hospitals that have a disproportionate share of low-income patients. Hospitals in low-wage areas will receive more money to help them compete with other hospitals for workers. The Medicare payments will help the hospitals in low-wage areas pay higher wage rates.

Inpatient, outpatient and covered skilled nursing facility services provided by a critical access hospital will be reimbursed at 101 percent of reasonable costs of services furnished to Medicare beneficiaries. Critical access hospitals can operate up to 25 beds. A requirement that only 15 of the 25 beds be used for acute care at any time will be dropped.

On or after Jan. 1, 2005, Medicare reimbursement of on-call emergency room providers will be expanded to include physician assistants, nurse practitioners and clinical nurse specialists as well as emergency room physicians.

• **Physicians.** Physicians serving in rural areas that have a low number of physicians available to serve beneficiaries will receive an additional 5 percent in Medicare payments from 2005 to 2007.

• **Ambulance services.** Payments will be based on the ambulance service's fee blended with either the national fee schedule amount or a combined rate of the national fee schedule and a regional fee schedule, whichever results in the larger payment.

Payments for ground ambulance services will be increased by one-quarter of the per-mile payment rate otherwise established for trips longer than 50 miles occurring on or after July 1, 2004, and before Jan. 1, 2009.

For qualified rural ambulance areas, the HHS secretary will provide a percentage increase in the base rate of the fee schedule for ground ambulance services furnished on or after July 1, 2004, and before Jan. 1, 2010. Qualified rural areas are those in which the lowest population densities collectively represent a total of 25 percent of the population in the general area.

In addition, payments for ground ambulance services originating in a rural area will be increased by 2 percent (on top of increases for payments for long trips and for low density areas) for services furnished on or after July 1, 2004, through Dec. 31, 2007. The fee schedule for ambulances in other areas (after the long trip adjustment) will increase by 1 percent.

• **Home health care.** Rural home health care providers will receive a 5 percent bonus from April 2004 to April 2005.

Drug Importation

• **Certification.** Prescription drugs can be imported from Canada, but only if the HHS secretary certifies the safety of the drugs and that the practice saves consumers money.

The HHS secretary, in consultation with appropriate government agencies, will study problems with implementation of existing drug importation law, including safety concerns and anti-counterfeiting technologies that could be used to help ensure the safety of imported drugs.

HHS and other agencies will be required to conduct a study and report on drug pricing practices of countries that are members of the Organization for Economic Cooperation and Development. The study also must evaluate how the reduction or elimination of price controls and similar practices could lower prices for U.S. consumers.

Generic Drugs

• **Patient protections.** Brand-name pharmaceutical manufacturers will receive only one 30-month stay of their patent protection while applications for generic versions of their drug are considered, but only if the brand-name patent application was submitted before that of the generic drug.

• **Qualifications.** Multiple companies can qualify for the 180-day market exclusivity as long as they file all of their applications on the first day of eligibility.

• **Judgments.** Generic drug companies will have an improved ability to obtain declaratory judgments against brand-name drugmakers in court and move a generic version to the market more quickly.

Medicare Parts A and B

• **Income relating.** Beginning in 2007, Part B Medicare premiums will be subsidized on the following income schedule:

Singles' salaries: Under $80,000

Couples' salaries: Under $160,000

Premium subsidies: 75 percent

Singles' salaries: $80,000 to $100,000

Couples' salaries: $160,000 to $200,000

Premium subsidies: 65 percent

Singles' salaries: $100,000 to $150,000

Couples' salaries: $200,000 to $300,000

Premium subsidies: 50 percent

Singles' salaries: $150,000 to $200,000

Couples' salaries: $300,000 to $400,000

Premium subsidies: 35 percent

Singles' salaries: Over $200,000

Couples' salaries: Over $400,000

Premium subsidies: 20 percent

• **Average wholesale price.** Beginning in 2004, payment for many drugs under Medicare Part B will be reduced from 95 percent to 85 percent of the average wholesale price. Certain categories of drugs and drug products will continue to be paid at 95 percent of average wholesale price, including blood products and clotting factors.

Payments for some drugs under Medicare Part B can be further reduced to 80 percent of the average wholesale price in 2004, depending on data collected by the General Accounting Office and the HHS Office of Inspector General. Beginning in 2005, payment for these drugs will be either the average sales price plus 6 percent or through competitive acquisition program.

• **Preventative care.** Beginning on Jan. 1 2005, new beneficiaries will be allowed to receive a physical within six months of joining Medicare Part B. Screening and preventative services include mammographies, pelvic exams, bone mass measurement and screening for prostate cancer, glaucoma and diabetes.

As of Jan. 1, 2005, all Medicare beneficiaries will qualify for coverage of cardiovascular screening blood tests. Diabetes screening tests will be covered for individuals at risk of diabetes. Screening and diagnostic mammographies and intravenous immune globulin for treatment in the home of primary immune deficiency disease will also be covered.

• **Medicare Part B deductible.** The Medicare Part B deductible will remain at $100 through 2004 and will be $110 in 2005. In subsequent years, the deductible will be increased by the same percentage as the Part B premium increase, rounded to the nearest dollar.

• **Chiropractic services.** The HHS secretary will establish a two-year demonstration program at four sites to evaluate the feasibility and desirability of covering additional chiropractic services under Medicare. The projects cannot be implemented before Oct. 1, 2004.

• **Undocumented immigrants.** Medicare will spend $250 million in additional funding for each of the fiscal years 2005 through 2008 for emergency health services for undocumented immigrants. For each of the fiscal years 2005 through 2008, the HHS secretary must distribute $83 million of the $250 million among eligible providers in the six states with the highest number of apprehended undocumented immigrants.

• **Research.** The Agency for Healthcare Research and Quality will receive $50 million for fiscal 2004 to address the scientific information needs and priorities identified by the Medicare, Medicaid and State Children's Health Insurance Programs.

The Medicare law also authorizes $3 million for fiscal years 2005 and 2006 for the agency and the HHS secretary to establish a "Citizens' Health Care Working Group," which will submit a report to Congress and the president on issues such as the cost of health care and the role of evidence-based medicine and technology in improving quality and lowering costs.

Beneficiary Services

• **Medicare Contractors.** Medicare contractors must respond within 45 days of receiving a written inquiry. Contractors must also have a toll-free telephone number that beneficiaries, providers and suppliers can call to obtain information regarding billing, coding, claims, coverage and other Medicare information. Contractors are also required to identify the person supplying information and to monitor the accuracy, consistency and timeliness of the information provided.

The HHS secretary will be allowed to seek competitive bids for Medicare claims processing services at least every five years.

• **Medicare ombudsman.** The HHS secretary must appoint a beneficiary ombudsman no later than one year after enactment. The ombudsman will receive complaints, grievances and requests for information from beneficiaries and provide assistance.

• **Medicare appeals.** When claims are denied, Medicare must provide a written notice explaining why and notifying a beneficiary of his or her right to appeal. The notice also must tell the beneficiary how to appeal the decision.

• **Administrative agency.** A new Center for Beneficiary Services is established to administer Medicare Advantage, the prescription drug benefit and beneficiary information activities.

Regulatory and Contractor Reform

• **Regulatory relief.** New material cannot be added to final rules governing Medicare until the public is allowed to comment. New regulations and policies cannot be applied retroactively. Providers cannot be sanctioned if they follow written, erroneous guidance from the government or its agents.

• **Appeals.** Transfers Medicare administrative law judges from the Social Security Administration to the Department of Health and Human Services to ensure their independence.

• **Expedited review.** Expedites access to judicial review for legal issues that cannot be resolved administratively and requires expedited review of certain provider agreement determinations.

Cost Containment

• **Legislative requirement.** The president must submit legislation to Congress to curtail Medicare spending if general revenue contributions to the program are projected to pay more than 45 percent of total Medicare expenditures for two consecutive years. The House and Senate are required to follow specific guidelines for consideration of such legislation.

Beginning in 2005, the Medicare Board of Trustees' annual reports to Congress must include new information on Medicare spending. The information should include projections of growth in general revenue Medicare spending as a percentage of the total Medicare outlays for seven, 10, 50 and 75 years after the current fiscal year.

Health Savings Accounts

• **Paying for high deductibles.** Beginning Jan. 1, 2004, the measure establishes tax-free savings accounts, called Health Savings Accounts (HSAs), for individuals under age 65 who have high deductible insurance policies. No contributions can be made once an individual qualifies for Medicare.

For individual coverage, the plan must have an annual deductible of at least $1,000 for self-only coverage and $2,000 for family coverage. Out-of-pocket expenses must be no more than $5,000 for individual coverage and $10,000 for family coverage.

The maximum aggregate annual contribution that can be made to an HSA is the lesser of 100 percent of the annual deductible under the high deductible health plan or the maximum deductible permitted under an Archer Medical Savings Account high deductible health plan under present law, as adjusted for inflation. For 2004, the amount of the maximum high deductible is estimated to be $2,600 in the case of self-only coverage and $5,150 in the case of family coverage.

An employer can contribute to an individual's HSA. Individuals age 55 and older are allowed to make contributions beyond the standard limit. Those increases are $500 in 2004, $600 in 2005, $700 in 2006, $800 in 2007, $900 in 2008 and $1,000 in 2009 and thereafter.

Contributions to such accounts will be tax-free, as will distributions from such accounts if the funds are used for health care needs not covered by the insurance policies. Eligible expenses include Medicare Part A and Part B premiums, Medicare health maintenance organization premiums, and the employees' share of premiums for employer-sponsored retiree health insurance. Premiums for Medicare supplemental insurance known as Medigap are not included.

These accounts will be owned by the individual and will follow that person from job to job and into retirement. When the person dies, HSA ownership could be transferred to the person's spouse on a tax-free basis.